APPEAL NO. 93442

At a contested case hearing held on April 20, 1993, in (city), Texas, the hearing officer, giving presumptive weight to the report of the designated doctor, determined that the appellant (claimant) reached maximum medical improvement (MMI) on September 18, 1992, with an impairment rating of nine percent. In her request for review, claimant asserts the hearing officer erred in concluding that the designated doctor's report was entitled to presumptive weight, that claimant reached MMI on September 18, 1992, with an impairment rating of nine percent, and that the other medical evidence was insufficiently great to overcome the presumptive weight given the designated doctor's report. Claimant contends that the designated doctor's report was not entitled to presumptive weight because it was ambiguous, did not indicate that the designated doctor himself performed an evaluation, failed to assign a rating for claimant's wrist, and failed to follow the American Medical Association's Guidelines to the Evaluation of Permanent Impairment (AMA Guides) mandated by the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-4.24 (Vernon Supp. 1993) (1989 Act). The respondent (carrier) asserts that claimant's request for review is untimely and in the alternative urges our affirmance.

DECISION

Finding the evidence sufficient to support the challenged findings and conclusions, we affirm.

The carrier states that it received the hearing officer's decision in the mail at its city, Texas, office on May 3, 1993, that claimant's statement that she did not receive her copy, mailed to a post office box number in city Texas, until May 10th "is contrary to the usual and customary practice and presumption concerning the delivery of the mail," and asks that we dismiss the appeal as untimely. This we decline to do. We accept claimant's statement which is contained in her request for review prepared by her attorney, absent evidence to the contrary.

Claimant, the sole witness, testified that after her injury on June 12, 1991, she commenced treatment with Dr. M), who has continued to treat her back condition, and that Dr. M referred her to (Dr. C), who performed surgery on her right arm for a carpal tunnel syndrome (CTS) and who also has continued to see claimant. According to Dr. C's records of August 8, 1991, claimant provided a history of lifting some boxes on top of a shelf in a freezer at work which weighed about 30 pounds when the boxes fell and she caught them "with hyperextension injury to the bilateral wrist area with twisting injury to the cervical, thoracic, and lumbar spine region." Dr. C's examination noted a well healed scar on the back of claimant's neck. His impression included traumatic cervical, lumbar somatic dysfunction, bilateral upper extremity radiculopathy, and right leg radiculopathy. His recommended treatment included muscle relaxant and antiinflammatory medications, use of a TENS unit, and continued chiropractic treatment through Dr. M's office. He also noted that an EMG might prove necessary should pain persist.

According to Dr. C's record of January 8, 1992, an EMG was obtained on November 27, 1991, which showed a mild L3-L4 disc bulge with facet hypertrophy, and a complete fusion of the 4th, 5th, 6th, and 7th cervical vertebrae. Claimant's medical records indicated she had had neck surgery in 1978 after a fall. Dr C. recommended no spinal surgery but did inject claimant's right carpal canal and continued her wrist splints and her therapy and chiropractic treatment through Dr. M's office.

At the carrier's request, claimant was examined by (Dr. S), a neurologist, on January 23, 1992. He felt claimant needed a nerve conduction study to validate the diagnosis of CTS, noted she had a spur at C7-T1 "which could give difficulty in the hand," did not feel she needed any back or neck surgery at that time, and did not feel she should have a carpal tunnel release until EMG and nerve conduction studies were done. In his Report of Medical Evaluation (TWCC-69), Dr. S stated that claimant had reached MMI on January 23, 1992, with a 0% whole body impairment rating. We observe that although Dr. S's impairment rating appears to have been the first impairment rating assigned to the claimant, there is no evidence respecting whether she disputed that rating within 90 days of being advised of it pursuant to Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)). However, there was no disputed issue concerning the timely dispute of that rating and we need not further address the matter.

Claimant underwent electrodiagnostic studies on February 20, 1992, which were consistent with a mild CTS. Dr. C's report of February 26th stated claimant's EMG was positive for bilateral median nerve compression, the right side being worse than the left, and on March 31, 1992, Dr. C performed a right median nerve neurolysis. In a June 1st report, Dr. C stated that claimant had progressed well after her right median nerve neurolysis but had pain in her upper left extremity and that she would be scheduled for a left median nerve neurolysis.

In a June 30, 1992 report, Dr. M stated the diagnosis as lumbar plexus disorder, thoracic plexus disorder, and cervicobrachial syndrome to be treated with manipulation, electrical muscle stimulation, and cryotherapy. This report noted that claimant had successfully completed rehabilitation with a rehabilitation entity. In her TWCC-69 report, Dr. M certified that claimant reached MMI on July 15, 1992, with a whole body impairment rating of 25%. This report indicated Dr. M examined claimant on August 4, 1992, noted that Dr. C had recommended surgery on claimant's left hand, and stated she advised claimant to continue care on an as needed basis. Dr. C's 25% rating included 7% for the diagnosis, 1% for lumbar range of motion (ROM), 5% for lumbar neurological pain and discomfort, 10% for cervical ROM, and 4% for thoracic ROM. Dr. M's TWCC-69 referred to and had attached two reports from the National Rehab. Associates, dated July 24, 1992, which were entitled "Impairment Rating Measurements" and were signed by both Dr. M and a physical therapist. One of these reports contained the same spinal area impairment ratings and 25% whole body impairment rating as were contained in Dr. M's TWCC-69.

The second report contained a whole body impairment rating of six percent for claimant's upper extremity based on her right wrist. However, Dr. M did not include any rating for the right wrist in her TWCC-69. The claimant testified that while she agreed with Dr. M's 25% impairment rating (which did not include a rating for her hands), she disagreed with the MMI date.

Although not reflected in the record, apparently one or more of the parties raised a dispute concerning an impairment rating, an MMI date, or both, and the Texas Workers' Compensation Commission (Commission) selected (Dr. O), of the Dallas Impairment and Disability Evaluation Center (Evaluation Center), as the designated doctor to examine claimant and resolve the dispute. *See* Articles 8308-4.25(b) and 8308-4.26(g). In his TWCC-69 form, Dr. O stated that claimant reached MMI on September 18, 1992, with a whole body impairment rating of nine percent for her lumbar spine. Claimant said she visited Dr. O three times and was put through a battery of tests on the first visit which the records show was on August 10, 1992. She said that when she returned to Dr. O for a second visit, he told her he would rate her hands at 40% but wanted another EMG and sent her to (Dr. H). When she returned to Dr. O for the third visit, he reviewed Dr. M's records and Dr. H's report and told her that while he would go along with a rating for her back, he would not give her a rating for her hands as nothing showed up in Dr. H's studies. She said he had "the book" out and explained to her about his determination of her nine percent rating, but he could not rate her hands. She said she agreed with Dr. O's rating for her back but disagreed with his not rating her hands. As for MMI, claimant said that she was "about as well as I'm going to get."

According to the records referred to in Dr. O's TWCC-69, claimant was examined at the Evaluation Center on August 10, 1992, by (Dr. B) at Dr. O's request. In his detailed, unsigned report of claimant's history and physical examination, Dr. B stated that diagnostic studies had shown claimant to have bilateral CTS; that she had had surgery on the right side and had complete functional recovery; that she had not had surgery on the left side, but that examination revealed complete normal function also; that she had localized tenderness of the lumbar spine but no limitation of movement; and that she was on a full therapy program and appeared to be doing well. Upon completing his physical exam, Dr. B referred claimant for impairment evaluation though his report does not indicate to whom claimant was so referred. Also attached to Dr.O's report was the EMG and nerve conduction velocity study report of Dr. H, dated September 15, 1992, which indicated normal test results for claimant's upper extremities. Dr. H's impression was "chronic bilateral wrist pain, tendinitis." In his detailed narrative attached to his TWCC-69, Dr. O discussed how he arrived at claimant's nine percent whole body impairment rating based on the AMA Guides and attached a single page document entitled "Figure 8-4. Spine Impairment Summary" which contained handwritten notes.

According to an October 14, 1992, report, Dr. M saw claimant on September 29,

1992, reported her earlier diagnosis, continued her conservative treatment, iterated that claimant reached MMI on July 15, 1992, with a 25% impairment rating, and referred her for an EMG.

In a November 11, 1992, report, Dr. C noted a gradual return of pain to claimant's right upper extremity and scheduled a bilateral EMG by Dr. CC). In his January 20, 1993, report, Dr. C stated that claimant's January 20th EMG by Dr. CC showed evidence of cervical nerve root irritation with a thoracic outlet syndrome and median nerve compression. He stated that "[a]t this time, it is my opinion that the patient has a 15% disability to the right hand status post right median nerve neurolysis."

In her request for review, claimant asserts that Dr. O did not conduct her examination, that her evaluation was performed by Dr. O's staff, that Dr. O adopted the opinion of Dr. H instead of performing the evaluation himself, and that on her first visit she was seen exclusively by Dr. O's staff who conducted certain tests. Claimant cites us to Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993, where claimant says the same designated doctor's practice in this regard led to a reversal. In that decision we said that "a designated doctor can appropriately consider and rely on tests, exams, data, medical reports, etc. performed by others in arriving at his final evaluation in a given case." We went on to say that "as a part of the very important process of certifying MMI and impairment ratings, a designated doctor must himself also examine the injured party and not just review records and totally rely on examinations by others." In our view, the evidence in this case distinguishes it from Appeal No. 93095. In that case, the claimant testified that the designated doctor "didn't even lay his hands on me," and we remanded for the development of additional evidence because it appeared from the record that an examination by the designated doctor may well not have been performed. *And see* Texas Workers' Compensation Commission Appeal No. 93410, decided July 8, 1993, where we remanded for further development of the evidence as to whether the designated doctor performed an examination of the claimant who testified that the designated doctor spent about three minutes with him asking him questions and only had him "take three steps forward and three steps back and that was all."

It is evident from his report that Dr. O relied at least in part on Dr. B's examination, Dr. H's report, and upon various other tests and measurements attached to his report in reaching his determinations respecting claimant's MMI status and impairment rating. While Dr. O's narrative report does not specifically state that he personally examined the claimant, the claimant, referring to Dr. O, testified that on her visit the testing that "he did" lasted about two and one-half hours, that "he ran all the tests for my evaluation, for my impairment rating," and that "he run me through on all the machines as long as I could take the testing." Claimant was asked: "So you felt like he did a pretty thorough examination of you on the day you saw him and he was doing these tests. Is that correct?" She replied: "Yes, ma'am." Unlike the evidence in Appeals Nos. 93095 and 93410, *supra*, the evidence in this case

does not sufficiently raise an issue as to whether Dr. O personally examined claimant so as to cause us to remand for further evidence.

Claimant also asserts that Dr. O's report is ambiguous because there is a reference in some attached notes to claimant's right hand and to 40%. Assuming that, as claimant testified, Dr. O was at one time considering assigning an impairment rating for one or more of her hands, we fail to find fault in his deciding to obtain an EMG and nerve conduction studies from Dr. H before making that decision and, after reviewing Dr. H's report, in deciding against the assignment of any such impairment.

Claimant also complains that Dr. O's evaluation "was not based on objective clinical or laboratory findings to the extent of his evaluation of claimant's cervical spine and wrist injuries," and that Dr. O failed to correctly apply the AMA Guides in evaluating claimant's cervical spine and wrists. Claimant bases such assertions, essentially, on various items of information she finds in the reports of Drs. O and H and on her reading of various portions of the AMA Guides. The AMA Guides were not in evidence and no evidence was adduced at the hearing to support these assertions which claimant raises for the first time on appeal. Accordingly, we find them without merit. Articles 8308-4.25(b) and 8308-4.26(g) provide that the report of the designated doctor selected by the Commission is to be accorded presumptive weight concerning a disputed MMI date and impairment rating unless the great weight of the other medical evidence is to the contrary.

The ultimate determination of the attainment of MMI and of the extent of impairment, if any, must be made upon medical and not lay evidence. Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992. We have frequently noted the important and unique position occupied by the designated doctor under the 1989 Act. *See e.g.* Texas Workers' Compensation Commission Appeal No. 92555, decided December 2, 1992; Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We have just as frequently stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the medical evidence. Appeal No. 92412, *supra*. We are satisfied here of the correctness of the hearing officer's having accorded presumptive weight to the designated doctor's report upon determining that the great weight of the other medical evidence was not to the contrary. The 1989 Act provides that the hearing officer, as the fact finder, is the sole judge not only of the relevance and materiality of the evidence but also of its weight and credibility. Articles 8308-6.34(e) and (g). Not only did Dr. O determine that claimant had reached MMI on September 18, 1992, with a 9% impairment rating, one of claimant's own treating doctors, Dr. M, had earlier determined she had reached MMI on July 15, 1992, albeit with a 25% rating. Like Dr. O, Dr. M also gave claimant no impairment rating for her hands or wrists. Dr. S as far back as January 23, 1992, determined claimant had reached MMI with no impairment. Aside from claimant's lay testimony, the only medical evidence to the contrary was the opinion of Dr. C that claimant had "a 15% disability to the right hand."

The challenged findings and conclusions are not so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 751 S.W.2d 629 (Tex. 1986).

The decision of the hearing officer is affirmed.

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Philip F. O'Neill
Appeals Judge

CONCUR:

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Thomas A. Knapp
Appeals Judge

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Gary L. Kilgore
Appeals Judge